DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

072 11/12/11

PRINTED: 10/04/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, SPARTA SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG F 281 SS=D F 281 SS=D F 281 This plan of correction is submitted as required under state and federal law. The submission of this plan does not constitute an admission on the part of NHC HealthCare Sparta as to the accuracy of the surveyor's findings not the conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of NHC HealthCare Sparta as to the accuracy of the surveyor's findings not the conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of NHC HealthCare Sparta as to the accuracy of the surveyor's findings not the conclusions drawn there from. The facility's submission of the plan of correction does not constitute an admission on the part of the facility that the findings are accurate, that the findings constitute a deficiency, or that the score and severity regarding any of the deficiencies cited are correctly applied. F 281 – services provided meet professional standards	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NHC HEALTHCARE, SPARTA XX, ID REFERX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE CONTINUE SIZE CROSS-REFERENCED TO THE APPROPRIATE CONTINUE ACTION SIZE CROSS-REFERENCED TO THE APPROPRIATE CONTINUE ACTION SIZE CROSS-REFERENCED TO THE APPROPRIATE CONTINUE SIZE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE A			445130 B. V				09/28/2011		
F 281 SS=D PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility failed to ensure staff provided urinary catheter care according to facility policy for one (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on August 5, 2010, with diagnoses to include Congestive Heart Failure, Atrial Fibrillation, Atherosclerotic Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitus, Obstructive Sleep Apnea, Prostate Cancer Status Post Radiotherapy, Benign Prostatic Hypertrophy, Glaucoma, Cerebrovascular Accident, Coronary Artery Bypass Graft and CPAP (continuous positive air pressure breathing device). Review of the Minimum Data Set completed on August 10, 2010 revealed the resident had memory problems; required extensive assistance with transfers, bathing, dressing, and grooming; was occasionally incontinent of bowel and bladder; was able to self-feed a low fat, low cholesterol No Added Salt Controlled Carbohydrate diet.	NHC HE.	NHC HEALTHCARE, SPARTA (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	34 GRACEY ST SPARTA, TN 38583 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		OULD BE	LD BE COMPLETE	
BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	SS=D	The services provice must meet profession must meet profession. This REQUIREMENT by: Based on medical review, and intervies staff provided urina facility policy for one reviewed. The findings included Resident #2 was addeduced to the findings included Review of the Minimal August 10, 2010 reviewed to the Minimal Review of the Minimal Review of the Minimal M	ded or arranged by the facility ional standards of quality. NT is not met as evidenced record review, facility policy by, the facility failed to ensure ry catheter care according to e (#2) of five residents ed: Imitted to the facility on August by the sestion of the facility on August by the facility of the facility on August by the facility of the facility on August by the facility of the facility o		281	This plan of correction is submitted under state and federal law. The subthis plan does not constitute an admitted part of NHC HealthCare Sparta a accuracy of the surveyor's findings in conclusions drawn there from. The fisubmission of the plan of correction constitute an admission on the part facility that the findings are accurate findings constitute a deficiency, or thand severity regarding any of the decited are correctly applied. F 281 – services provided meet profistandards Resident # 2 was discharged from the 8-7-2010 and did not return to the fallo-12-11 all residents who have Folewere reviewed by the Director of Nurverify that Output records were composited to for signs of urine or infections and compare the documentation in the resident's reconstitute or infections and requirement per recording outputs and proper documentation in the resident of the regarding signs of leaking of urine or infections and requirement per recording signs of leaking of urine or infections and proper documentation in the resident of the regarding signs of leaking of urine or infections and proper documentation in the resident of the regarding signs of leaking of urine or infections and proper documentation in the resident of the regarding signs of leaking of urine or infections and proper documentation in the resident of the regarding signs of leaking of urine or infections and proper documentation in the resident of the regarding signs of leaking of urine or infections and proper documentation in the resident of the series of the sum of the sum of the series of the sum of the su	omission of hission on as to the lot the score ficiencies lot	10-12-13	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

75711 Facility ID: TN9404 0CT 1 3 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/04/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED		
		445130	B. WI	۷G _	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	18	C 8/2011	
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	3 S	PREET ADDRESS, CITY, STATE, ZIP CODE 4 GRACEY ST SPARTA, TN 38583 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE		
	able to void and pail approx. (approximal Penis and scrotume Nurse Practitioner). cath (proper name French 10 ml (millilit (patient) very uncome Had return of 50 ccurine". Continued rethe same day at 6:00 here. Made aware or review of nursing no record revealed no I recording urine output documentation in the Foley catheter output Review of nursing no 9:15 a.m., revealed (shortness of breath) (saturation) 90%. Cray (right and left) lower Pt. put C-pap (device Discussed sending proposes requests we facility before sending swollen and what apparound catheter (notified of pt. condition removing Foley put in void, may not be able unable to void". La milligrams given per continued review of recordinated recordina	"complained of not being in. Voided in urinal earlier tely) 200 cc amber urine. Sedematous; called (named New order received. Foley of a urinary catheter) 16 ter) bulb inserted. Pt. Infortable during procedure. (centiliters) dk (dark) amber view of nursing notes from 0 a.m., revealed "spouse if new orders". Further tes as well as the medical ntake and Output sheet for ut nor was there any enurses' notes regarding it. Interest dated August 7, 2010, at itPt. complains of SOB of Color (Contiliters) sat ackles present to (R) & (L) lobes, crackles in (R) upper it is to assist with breathing) on. It to ER (emergency room). It is to ER (emergency room). It is to be blood leaking Named Nurse Practitioner) on. Discussed concern of it D/T (due to) not able to be to reinsert D/T swelling if six (diurectic medication) 40 order.	F2	281	F 281 cont. Director of Nursing or Unit Manager was compliance of output being recorded of infection through the quality assurated process. Output sheets will be monitod in x 8 weeks and Director of Nursing or UM Manager will visibly check residents was catheters to look for signs of leaking of infections and compare that with document in the resident's record. Findings of the assurance monitor will be reported by Director of Nursing to the Quality Assurance which is made up of the following people: Medical Director, Administrated Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coord and Wound Care Nurse.	and signs ance red weekly Unit ith Foley r urine or umentation e quality the irance llowing or,		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445130	B. WII			1	C 8/2011
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, SPARTA				34	EET ADDRESS, CITY, STATE, ZIP CODE 4 GRACEY ST PARTA, TN 38583		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Practitioner). New of hospital) for evaluated notes at 3:00 p.m., stretcher with EMTs technicians)" Cornotes revealed no dithe earlier bleeding catheter. Review of nursing in Department (ED) dap.m., revealed "Pt (amount) of light brooked blood noted to in Continued review of p.m., revealed " For around meatus. Son Continued review of revealed the residen (milligrams) intraven notes at 7:20 p.m., rewith clots (named necessity of CBI (conduct to blood clots" at 8:45 p.m. revealed type of urinary cathed started. Penis swolled clots in old bag. Blooked penis swolled clots in old bag. Blooked penis swolled clots in old bag. Blooked penis at 9:45 p.m., refrom CBI bag empties. Review of the hospital Physician dated August patient admitted deupon changing of the due to repeated foley.	order to send pt. to (named tion. Further review of nursing revealed " pt. left on a (emergency medical national review of nursing ocumentation of the status of which was noted around the otes from the Emergency ated August 7, 2010, at 4:12, incontinent of small amt own stool. Pt. cleaned. Bright meatus around Foley" ED nursing notes at 7:18 oley checked. Draining blood one small clots in tubing". notes at the same time at received Lasix 40 mg rously. Further review of evealed "urine now bloody physician) informed of nationals bladder irrigation). Continued review of notes defined the same time at the same time of the same time	F	281			

FINITED. TUTOMIZUTI DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 445130 09/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 34 GRACEY ST NHC HEALTHCARE, SPARTA SPARTA, TN 38583 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 281 Continued From page 3 F 281 obstructed, thus was not able to urinate...continuous urinary baldder irrigation was started and the bleeding/clots stopped.' Review of the facility policy entitled "Catheter Care - Anchored" revealed "Observe area around catheter for any signs of leaking of urine or infection, such as redness, swelling...and Outputs should be kept on a any patient with a catheter and maintained until second voiding after Foley is discontinued". Interview with the Unit Manager on September 28, 2011, at 1:20 p.m., in the conference room, revealed the resident was voiding fine on admission. Continued interview revealed the patient's spouse wanted the patient to be treated at the facility first and was asked twice if ... wanted them to send the resident out.. During further interview, the Unit Manager confirmed there was no Intake and Output form in the resident's record. Continued interview with the Unit Manager confirmed there was no nursing

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RESTORE BLADDER

F 315

SS=D

documentation of the resident's output after the Foley catheter was inserted through discharge from the facility and there was also no ensuing documentation of the status of the resident's bleeding around the Foley catheter from 9:15 a.m. when it was initially noted through the resident's discharge from the facility at 3:00 p.m.

483.25(d) NO CATHETER, PREVENT UTI,

indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an

Event ID: 7R5711

Facility ID: TN9404

F 315

If continuation sheet Page 4 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED			
	445130			۱G _	1	C 8/2011				
	ROVIDER OR SUPPLIER	8		STREET ADDRESS, CITY, STATE, ZIP CODE 34 GRACEY ST SPARTA, TN 38583						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
	who is incontinent of treatment and service infections and to restruction as possible. This REQUIREMENT by: Based on medical the facility failed to resident with a Fole complications and finformation for one reviewed. The findings include Resident #2 was ad 5, 2010, with diagnor Heart Failure, Atrial Cardiovascular Disease Mellitus, Obstructive Cancer Status Post Prostatic Hypertroph Cerebrovascular Ac Bypass Graft, and Opressure breathing of Review of the Minim August 10, 2010 reviews occasionally incompany problems; reviews occasionally incompany problems.	necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder e. IT is not met as evidenced record review and interview, ensure staff monitored a y catheter to prevent ailed to document appropriate (#2) of five residents ed: mitted to the facility on August ses to include Congestive Fibrillation, Atherosclerotic ease, Chronic Obstructive Hypertension, Diabetes es Sleep Apnea, Prostate Radiotherapy, Benign hy, Glaucoma, cident, Coronary Artery PAP (continuous positive air device). sum Data Set completed on ealed the resident had required extensive assistance and, dressing, and grooming; continent of bowel and self-feed a low fat, low	F	315	F315 – No Catheter, prevent UTI, R bladder Resident # 2 was discharged from the 8-7-2010 and did not return to the factor of 10-12-11 all residents who have Followere reviewed by the Director of Noverify that Output records were complirector of Nursing also visibly check with Foley catheters to look for sign of urine or infections and compare to documentation in the resident's recording or all licensed staff regarding Care procedures and requirement precording outputs and proper documentation in the resident's recording outputs and proper documentation in the quality assupprocess. Output sheets will be monitor as weeks and Director of Nursing or Manager will visibly check residents acatheters to look for signs of leaking infections and compare that with down in the resident's record. Findings of the assurance monitor will be reported be Director of Nursing to the Quality Assumance of Nursing to the Quality Assumance of Nursing to the Reported be Director of Nursing to the Realth Information Manager, Social Services Director, Fa Prevention Nurse, Facility Rehab Cooland Wound Care Nurse.	the facility on facility. On ey catheters ursing to inplete, ked residents is of leaking that with ord. On 10-d in-service ing Catheter ertaining to innentation infection. will monitor d and signs rance for different weekly. Unit with Foley or urine or cumentation in the quality by the surance following tor, on lls	10-12-11			

		AND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			IRVEY TED
		445130	B. WIN	IG		09/28	3/2011
NAME OF PROVIDER OR SUPPLIER				34	EET ADDRESS, CITY, STATE, ZIP CODE 4 GRACEY ST		
NHC HEA	ALTHCARE, SPARTA			S	PARTA, TN 38583		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	00000	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	age 5	F:	315			
	5:00 a.m., revealed able to void and pa approx. (approxima Penis and scrotum Nurse Practitioner). cath (proper name French 10 ml (millil (patient) very uncor Had return of 50 courine". Continued rethe same day at 6:0 here. Made aware review of nursing name record revealed no recording urine out documentation in the Foley catheter output Review of nursing results of saturation) 90%. Continued rethe same day at 6:0 here. Made aware or revealed no recording urine output documentation in the Foley catheter output Court of nursing results of saturation) 90%. Confight and left) lowe Pt. put C-PAP (devion. Discussed sent room). Spouse requour facility before securrently swollen ar leaking around cather actitioner) notified concern of removing able to void, may not swelling if unable to medication) 40 milling medication) 40 milling approximation of the province of the prov	notes dated August 7, 2010, at "Pt. complains of SOB					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7R5711

Facility ID: TN9404

If continuation sheet Page 6 of 8

		AND HUMAN SERVICES					. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY ETED
		445130	B. WI	۱G _		ECTION HOULD BE CON	
	ROVIDER OR SUPPLIER		-1		TREET ADDRESS, CITY, STATE, ZIP CODE 34 GRACEY ST SPARTA, TN 38583		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 315	received and called Practitioner). New of hospital) for evaluation nursing notes at 3:0 stretcher with EMT technicians)" Conotes revealed no of the earlier bleeding catheter. Review of nursing in Department (ED) dop.m., revealed "P (amount) of light bried blood noted to Continued review of p.m., revealed " Faround meatus. So Continued review of revealed the reside (milligrams) intravenotes at 7:20 p.m., with clots (namenecessity of CBI (conduct to blood clots) at 8:45 p.m. revealed type of urinary cathes started. Penis swoll clots in old bag. Blo Foley, 30 ml bulb in notes at 9:45 p.m., from CBI bag empting the started of the started of the same continued to the same clots in old bag. Blo Foley, 30 ml bulb in notes at 9:45 p.m., from CBI bag empting the started of the same continued to the same clots in old bag. Blo Foley, 30 ml bulb in notes at 9:45 p.m., from CBI bag empting the same clots in old bag empting the same clot	n., revealed "lab results I to (named Nurse order to send pt. to (named tion. Further review of the 20 p.m., revealed " pt. left on s (emergency medical ntinued review of nursing documentation of the status of which was noted around the notes from the Emergency ated August 7, 2010, at 4:12 t, incontinent of small amt own stool. Pt. cleaned. Bright meatus around Foley" If ED nursing notes at 7:18 Foley checked. Draining blood me small clots in tubing" If notes at the same time int received Lasix 40 mg nously. Further review of revealed "urine now bloody d physician) informed of continuous bladder irrigation) Continued review of notes ed " 22 - 3 way (size and eter) Foley inserted. CBI len. 850 ml bloody urine with body urine return with new offated". Further review of revealed "2650 ml pink urine	F	315	5		
	Physician dated Au "patient admitted	gust 8, 2010, revealed due to frank blood per urethra ne foley (possibly from trauma					

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Event ID: 7R5711

Facility ID: TN9404

If continuation sheet Page 7 of 8

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 445130 09/28/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 34 GRACEY ST NHC HEALTHCARE, SPARTA **SPARTA, TN 38583** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 315 Continued From page 7 F 315 due to repeated foley placement). The blood clots were numerous and the pt. was repeatedly obstructed, thus was not able to urinate...continuous urinary baldder irrigation was started and the bleeding/clots stopped." Review of the facility policy entitled "Catheter Care - Anchored" revealed "Observe area around catheter for any signs of leaking or urine or infection, such as redness, swelling...and "Outputs should be kept on a any patient with a catheter and maintained until second voiding after Foley is discontinued". Interview with the Unit Manager on September 28, 2011, at 1:20 p.m., in the conference room, revealed the resident was voiding fine on admission. Continued interview revealed the patient's spouse wanted the patient to be treated at the facility first and was asked twice if ... wanted them to send the resident out.. During further interview, the Unit Manager confirmed there was no Intake and Output form in the resident's record. Continued interview with the Unit Manager confirmed there was no nursing documentation of the resident's output after the Foley catheter was inserted through discharge from the facility and there was also no ensuing

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documentation of the status of the resident's bleeding around the Foley catheter from 9:15 a.m. when it was initially noted through the resident's discharge from the facility at 3:00 p.m.

Event ID: 7R5711

Facility ID: TN9404

If continuation sheet Page 8 of 8